

The ALJ denied claimant's request for authorized medical treatment, finding that claimant did not meet her burden of proof in establishing that she suffered an accidental injury which arose out of and in the course of her employment with respondent. The ALJ determined that claimant failed to prove she suffered a cumulative trauma injury, and that her nonspecific complaints of pain do not constitute an injury. Claimant, however, argues that the ALJ erred and that the greater weight of the credible evidence contained in the preliminary hearing record, which includes claimant's medical treatment records, her

testimony and the report of the independent medical evaluation (IME) performed by board certified physical medicine and rehabilitation specialist Pedro A. Murati, M.D., proves that claimant's regular heavy work duties from July 2010 through February 5, 2011, her last day worked before her surgery, prove that claimant injured her low back and left leg while employed by respondent. Respondent contends that claimant's back problems stem from her pre-existing bilateral knee problems, and not from her work with respondent.

FINDINGS OF FACT

After reviewing the record compiled to date, the undersigned Board Member concludes the preliminary hearing Order should be affirmed.

Claimant was employed as an alternate manager for respondent. Until the time of her layoff on July 5, 2011, claimant had worked for respondent or its predecessors for 23 years. As an alternate manager at respondent, claimant was a working supervisor, which meant that she would fill in when an employee was absent. Her duties included cooking, cleaning and helping with the production schedule. She had to do a lot of bending, standing and walking. Claimant also had to lift canned goods, food boxes, vegetables and milk. The boxes of food she had to lift, included boxes of meat weighing up to 40 pounds and cartons of eggs weighing 30 pounds. Claimant testified that she loads everything onto a cart, loading five carts every morning.

Prior to 2010, in the 20 or so years before, claimant had filled out incident reports on her back and other body parts. She had experienced back problems off and on. But she would take Tylenol, and then the problems would go away. Those earlier back problems did not last for a long period of time. Claimant acknowledged that she did file a claim for permanent benefits relating to her hands and neck in 1994 or 1995.

Before 2010, claimant had never had problems with pain down her left leg. In 2010, claimant began having pain in her left calf. She testified that she did not have a specific accident. She had pain up underneath her left¹ foot and she would feel numbness when she would stand for a prolonged period of time at work, and then gradually it went to her back. She was on her feet constantly at work.

Before these problems started in 2010, claimant never had the same kind of pain and problems in her leg and back as she was having in 2010. The pain was made worse by prolonged standing or sitting. Claimant continued to work through February 2011. Her back and leg pain worsened as she continued to work. Claimant was still doing the lifting of boxes and performing other duties, anything that needed to be done.

¹ See P.H. Trans., Cl. Ex. 1 at 11 (Dr. Yorke's Aug. 17, 2010 report).

In July 2010, claimant sought treatment with her family doctor, Todd A. Frieze, M.D. She was referred to board certified neurological surgeon, Craig H. Yorke M.D. who then referred her to board certified neurological surgeon, John D. Ebeling, M.D.

Claimant continued to do her job, trying to ignore the pain. But finally, the pain got so bad, she decided to have the back surgery. Claimant had the surgery on February 7, 2011. Her last day worked before the surgery was February 5, 2011.

After the surgery, claimant was off work for a period of time, returning to work in March 2011. Claimant continued to work for respondent until July 2011, when, due to the building renovation, claimant was laid off. Her last day working for respondent was July 5, 2011. However, claimant anticipates being called back to work, but does not know when that will be.

When claimant was asked what caused her back and leg to become so painful that she had to have surgery, she answered that it is the work that she does, the bending, the walking, the lifting. "Whatever I need to do at work that's what I do. If I have to cook, if I have to help them clean, I clean." When she was asked why she did not fill out an incident report for her back and leg pain, claimant testified, "When I have - - when I have pain I go to my doctor and when my leg started bothering me I didn't think it was anything else. I just went, went to my doctor for it. When I - - when it kept bothering me and bothering me I kept going back to the doctor, so, I just kept - - I just kept working and it kept getting worse."²

Claimant testified that when her knees and back started hurting, she knew that it was from the job standing on that concrete floor. But she kept doing that job until February 5, 2011.

Claimant also attributed her current back pain to difficulties she was having with walking due to her knees. She testified that it was in 2010 when she first started to notice that she was having difficulty walking in a normal fashion. However, claimant admitted that as early as 2008, she was having difficulty walking because of pain in her knees. She testified that is what caused her back pain, which has not subsided since 2010.³ Claimant acknowledged, at the time of the preliminary hearing, she was having pain in both knees, left worse than right.

When asked whether over the last several years at work, she has had any single incident that caused her injury, claimant responded that one time, when she was picking up rations, she pulled something in her back. That incident occurred sometime in 2010.

² *Id.* at 16

³ *Id.* at 18-19.

She did not fill out an accident report and she did not seek medical treatment in this instance; she just took some Tylenol.

While claimant was off work for surgery, from February 5, 2011, until sometime in March 2011, her symptoms improved somewhat. When claimant returned to work in March 2011, she was working on light duty.⁴ The light-duty work involved no bending, lifting, prolonged standing, sitting or twisting. Claimant testified that the light-duty work was alright. But when she worked on the serving line at work, she experienced back pain, so she had to take a break and sit down for 10 minutes or so.⁵

At the request of respondent, claimant saw board certified internal medicine specialist Chris D. Fevurly, M.D. Claimant acknowledged that she provided Dr. Fevurly with an accurate medical history when she saw him. When she was asked if Dr. Fevurly correctly recorded her medical history when he indicated that she had suffered an injury to her low back in 1991, claimant replied, "I don't know." And when claimant was asked if she recalled telling Dr. Fevurly that in June 1991, she was the driver of an automobile and was involved in a motor vehicle accident, she replied, "I don't remember."

When claimant was asked if Dr. Fevurly reported that information (regarding a prior automobile accident and a prior low back injury) in the report that he authored, would she have any reason to contradict that information, claimant replied, "No."

Claimant saw Dr. Frieze on July 26, 2010, and he referred her to physical therapy for low back pain and left leg sciatica. Dr. Frieze saw claimant again on September 23, 2010, and ordered epidural steroid injections.⁶

Dr. Frieze referred claimant to Dr. Yorke on August 17, 2010. He saw claimant again on September 21, 2010. Dr. Yorke's September 21, 2010, medical note indicated, "She is particularly uncomfortable in the mornings and particularly on Wednesdays and Thursdays because of the amount of walking that she is required to do at work." At that time, Dr. Yorke prescribed a lumbar epidural steroid injection.⁷

Claimant was referred by Dr. Yorke for a surgical consultation with Dr. Ebeling on January 13, 2011. Claimant reported continuing low back left sciatica type leg pain. Dr. Ebeling's review of her MRI scan showed a pronounced disc protrusion and bulge at L4-5 along with facet hypertrophy, which would contribute to lateral recess stenosis and nerve

⁴ This was pursuant to Dr. Ebeling's restrictions. (See Claimant's Brief at 3.)

⁵ P.H. Trans. at 20.

⁶ *Id.*, Cl. Ex. 1 at 9-10 (Dr. Frieze's referral forms).

⁷ *Id.*, Cl. Ex. 1 at 25 (Dr. Yorke's Sept. 21, 2010 office note).

root impingement on the left. At L5-S1, she had lateral recessed narrowing and impingement of the S1 nerve root. Dr. Ebeling recommended surgery.

On February 7, 2011, Dr. Ebeling performed a left L4-5 laminotomy, foraminotomy and discectomy and a left L5-S1 laminotomy, foraminotomy and inspection of the disc. On March 28, 2011, Dr. Ebeling released claimant to return to light-duty work for two months, and then as tolerated. On May 30, 2011, he released claimant for regular work.

Claimant returned to see Dr. Frieze post surgery on April 29, 2011, and he referred claimant to physical therapy. In a medical note dated May 27, 2011, Dr. Frieze extended Dr. Ebeling's light-duty restrictions by another 30 days.

On April 12, 2011, claimant saw Pedro A. Murati, M.D., for an IME, at the request of her attorney. Claimant complained of low back pain when lying on her back, and occasional pain in her left knee and calf which since the surgery, is not as bad. She also complained that prolonged walking and prolonged sitting increased her low back pain.⁸

On examination, Dr. Murati found that claimant's MSRs [muscle strength reflexes] in her bilateral lower extremities to reveal a missing right ankle jerk and missing left hamstring reflex. Sensory examination to pinprick of the bilateral lower extremities revealed to be intact. Muscle strength testing of the bilateral lower extremities revealed 4/5 left great toe extensor. There was mild atrophy of the left calf.

Examination of the back revealed the L5 spinous process to be most tender to palpation with very increased tone noted bilaterally. Pelvic brim examination revealed the right to be rotated forward and the left to be hiked. There was negative axial load, axial rotation, distraction and flip examination. There were tight hamstrings noted bilaterally. There was a healed surgical incision. There was mild atrophy of the left calf and mild atrophy of the left thigh. There was a negative pelvic compression examination bilaterally. SLRs were grossly measured to be negative bilaterally. There was a positive SI examination bilaterally.

A knee examination revealed a negative McMurray's examination bilaterally, as well as a negative drawer, instability and Lachman's examination bilaterally. There was mild crepitus of the left knee. There was positive medial and lateral patellar apprehension. Claimant ambulated with decreased stance phase on the left.⁹

⁸ *Id.*, Cl. Ex. 1 at 1 (Dr. Murati's Apr. 12, 2011, report).

⁹ *Id.*, Cl. Ex. 1 at 3 (Dr. Murati's Apr. 12, 2011 report).

An MRI of the lumbar spine dated July 16, 2010, showed an annular tear at L4-5 and degenerative disk disease at multiple levels, as well as a bulge at L4-L5 and L5-S1. An MRI of the left knee dated January 4, 2008, showed an effusion.¹⁰

Dr. Murati diagnosed claimant status post, left L4-5 laminectomy, foraminotomy and diskectomy; left L5-S1 laminotomy, foraminotomy and inspection of the disk; bilateral SI dysfunction; and left patellofemoral syndrom. He opined that these diagnoses are, within reasonable medical probability, a direct result of claimant's work-related series of accidents through February 5, 2011.¹¹

For the bilateral SI dysfunction, Dr. Murati recommended cortisone injections, as well as physical therapy with possible instruction on use of the SI belt and/or gait training. He also recommended anti-inflammatory medications and pain medication as needed. For the left patellofemoral syndrome, he recommended cortisone injections and, if no improvement, Synvisc injections. Dr. Murati also recommended knee braces, as well as anti-inflammatory medications and pain medication as needed.

Dr. Murati's restrictions for claimant were to work as tolerated and use common sense.¹²

Claimant saw Dr. Fevurly for an IME at the request of respondent on June 21, 2011. Dr. Fevurly was provided with medical records for his review, and performed a physical examination on claimant. Claimant displayed an obviously antalgic limping-type gait. She was unable or unwilling to do more than about a one-quarter to one-half squat. She was able to do a toe and heel walk, and had no trouble with transfers on and off the examination table. There was no atrophy found. Dr. Fevurly "did measure the calves circumferences; 35 cm and there is no quadriceps atrophy in either lower extremity."¹³

Claimant demonstrated relatively well preserved range of motion in the cervical spine with a well-healed horizontal anterior cervical spinal surgery scar. Claimant had undergone a C4-5 anterior cervical diskectomy on June 24, 1994, for a work-related C4-5 disc herniation. She had a negative Spurling's test and really no tenderness over the cervical spine or paraspinal musculature of the cervical area.

Claimant demonstrated full range of motion of the shoulders. There was mild pain at the extreme ranges of abduction and external rotation, but really no evidence for

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*, Resp. Ex. A at 5 (Dr. Fevurly's Jun. 21, 2011 report).

impingement and no weakness on rotator cuff testing. The upper extremity examination otherwise showed no motor, sensory or deep tendon reflex deficits and no sensory loss. And, all in all, the upper extremity examination was unremarkable. Claimant had mild tenderness over the mid-thoracic spine, but no visible spasms.

Claimant had a well-healed surgical scar over the lumbar area with mild loss of normal lumbar lordosis. There was generalized tenderness throughout the low back, left greater than right. Range of motion of the low back was limited with forward bend to 50 degrees, extension to 10 degrees and lateral bend to 10 to 15 degrees with complaints of low back pain at the extreme ranges of lumbar motion.

Claimant had no neurological deficits in the lower extremities. She had no motor deficits. She had excellent plantar and dorsi flexor strength and normal EHL strength. Sensory examination was normal and the knee jerks were 1/4 and symmetric. The ankle jerks were 2/4 and symmetric, Babinski's were down going and straight leg raising did not produce a sciatic stretch abnormality in either lower extremity. Bowstring and Bragard's tests were symmetrically negative.

A knee examination showed no retropatellar crepitation. Claimant had excellent and full range of motion in both knees with flexion to 140 degrees and full extension. She did have pain upon patellar compression grind test bilaterally, but there was no abnormality or unusual joint line tenderness in either knee. McMurray's testing was unremarkable. Anterior drawer sign and Lachman's tests were normal. There was no instability to valgus or varus stress testing.

Dr. Fevurly diagnosed claimant with an antalgic gait related to bilateral knee pain which claimant reported as the cause of her recurrence of her low back pain from 2008 to 2011. The examination was consistent with mild patellofemoral chondromalacia, but no significant evidence was found for tibiofemoral degenerative arthritis. There was no current evidence of internal derangement of either knee. Dr. Fevurly also diagnosed development of lumbar pain with associated left lower extremity lumbar radiculopathy. He opined that this is related to degenerative disk disease at L4-5 and L5-S1 with accompanying neuroforaminal stenosis and spinal canal stenosis. He also opined that this resulted from advancing degenerative spondylosis in the lumbar spine with no report of work injury as the cause of her low back pain in 2010. Dr. Fevurly diagnosed prior low back pain documented following a motor vehicle accident in 1991 and then further aggravated by a fall-related injury in 1993. And he diagnosed status post cervical discectomy at C5-6 for left cervical radiculopathy in 1994 resulting in dramatic improvement in her pain complaints and subsequent return to her full and regular duties.¹⁴

¹⁴ *Id.*, Resp. Ex. A at 6 (Dr. Fevurly's Jun. 21, 2011 report).

Dr. Fevurly opined that the medical records and clinical history outlined do not support claimant's report that the current complaints are work-related conditions. Her antalgic gait is related to mild to moderate bilateral patellofemoral chondromalacia. However, it is a degenerative process and not a traumatic process in this circumstance. Claimant's work duties, as described, are not significant contributors, accelerators or aggravators of the knee PFS/chondromalacia degenerative process.

Dr. Fevurly stated in his report that the MRI of the lumbar spine performed for claimant's surgery is consistent with advanced degenerative spondylosis in the lumbar spine associated with lumbar radiculopathy and lumbar stenosis from degenerative changes in the lumbar disc and bony hypertrophy. These preexisting degenerative conditions were allegedly aggravated by her antalgic gait, but there is no apparent relationship to her work duties.¹⁵

Dr. Fevurly stated that claimant has subsequently returned to work, although she is limiting her activities. The decision to limit her activity level is reasonable as a result of her chondromalacia patella and as a result of her advanced degenerative arthritis in the lumbar spine. However, the need for permanent restrictions or limitations is not work related. Claimant should look for a job that limits repetitive bending and stooping and limits her lifting to 30 pounds. The chondromalacia patella limits her ability to perform repetitive kneeling and squatting. These opinions are based upon a reasonable degree of medical certainty.¹⁶

PRINCIPLES OF LAW AND ANALYSIS

In workers compensation litigation, it is the claimant's burden to prove his or her entitlement to benefits by a preponderance of the credible evidence.¹⁷

The burden of proof means the burden of a party to persuade the trier of fact by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record.¹⁸

If in any employment to which the workers compensation act applies, personal injury by accident arising out of and in the course of employment is caused to an

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ K.S.A. 2005 Supp. 44-501 and K.S.A. 2005 Supp. 44-508(g).

¹⁸ *In re Estate of Robinson*, 236 Kan. 431, 690 P.2d 1383 (1984).

employee, the employer shall be liable to pay compensation to the employee in accordance with the provisions of the workers compensation act.¹⁹

The two phrases “arising out of” and “in the course of,” as used in K.S.A. 44-501, et seq.,

. . . have separate and distinct meanings; they are conjunctive and each condition must exist before compensation is allowable. The phrase “in the course of” employment relates to the time, place and circumstances under which the accident occurred, and means the injury happened while the workman was at work in his employer’s service. The phrase “out of” the employment points to the cause or origin of the accident and requires some causal connection between the accidental injury and the employment. An injury arises “out of” employment if it arises out of the nature, conditions, obligations and incidents of the employment.”²⁰

Claimant has presented conflicting testimony regarding the cause or aggravation of her low back complaints. Her pre-existing knee problems were discussed as being the cause at one point during the preliminary hearing. She also discussed her job duties with respondent as having caused or contributed to the low back condition. Dr. Murati adopted the work-related testimony, while Dr. Fevurly opined that the bilateral knee problems were the more likely culprit. The ALJ, after witnessing claimant’s testimony, determined that claimant had failed to prove a work-related cause or aggravation to the low back. This Board Member agrees. The testimony is conflicting and somewhat unpersuasive regarding claimant’s allegations of a work-related connection between her job and the low back symptoms. The denial of benefits by the ALJ is affirmed.

By statute, the above preliminary hearing findings and conclusions are neither final nor binding as they may be modified upon a full hearing of the claim.²¹ Moreover, this review of a preliminary hearing Order has been determined by only one Board Member, as permitted by K.S.A. 2010 Supp. 44-551(i)(2)(A), unlike appeals of final orders, which are considered by all five members of the Board.

CONCLUSIONS

Claimant has failed to prove that her current low back complaints are the result of a work-related accident arising out of and in the course of her employment with respondent. The denial of benefits in this matter is affirmed.

¹⁹ K.S.A. 2005 Supp. 44-501(a).

²⁰ *Hormann v. New Hampshire Ins. Co.*, 236 Kan. 190, 689 P.2d 837 (1984); citing *Newman v. Bennett*, 212 Kan. 562, Syl. ¶ 1, 512 P.2d 497 (1973).

²¹ K.S.A. 44-534a.

DECISION

WHEREFORE, it is the finding, decision, and order of this Appeals Board Member that the Order of Administrative Law Judge Rebecca Sanders dated July 6, 2011, should be, and is hereby, affirmed.

IT IS SO ORDERED.

Dated this ____ day of October, 2011.

HONORABLE GARY M. KORTE
BOARD MEMBER

c: Jeff K. Cooper, Attorney for Claimant
D'Ambra M. Howard/Ryan D. Wertz, Attorney for Respondent and its Ins. Carrier
Rebecca Sanders, Administrative Law Judge